

		FOR OHF USE					

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**2000
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2000)**

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: <u>0021550</u> Facility Name: <u>BOURBONNAIS TERRACE</u> Address: <u>133 MOHAWK DR.</u> <u>BOURBONNAIS</u> <u>60914</u> <div style="display: flex; justify-content: space-around; font-size: small;"> Number City Zip Code </div> County: <u>KANKAKEE</u> Telephone Number: <u>(847) 937-4790</u> Fax # <u>(847) 937-9321</u> IDPA ID Number: <u>36-2821184</u> Date of Initial License for Current Owners: <u>01/01/78</u> Type of Ownership: <div style="display: flex; justify-content: space-between;"> <div> <input type="checkbox"/> VOLUNTARY, NON-PROFIT <input type="checkbox"/> Charitable Corp. <input type="checkbox"/> Trust IRS Exemption Code _____ </div> <div> <input checked="" type="checkbox"/> PROPRIETARY <input type="checkbox"/> Individual <input checked="" type="checkbox"/> Partnership <input type="checkbox"/> Corporation <input type="checkbox"/> "Sub-S" Corp. <input type="checkbox"/> Limited Liability Co. <input type="checkbox"/> Trust <input type="checkbox"/> Other _____ </div> <div> <input type="checkbox"/> GOVERNMENTAL <input type="checkbox"/> State <input type="checkbox"/> County <input type="checkbox"/> Other _____ </div> </div>	
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In the event there are further questions about this report, please contact:
Name BOB KAGDA **Telephone Number:** (847) 675-3585

DPA 3745 (N-4-99)

IL478-2471

Print Preview

Facility Name & ID Number BOURBONNAIS TERRACE# 0021550 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days,
(must agree with license). Date of change in licensed beds _____

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	<u>100</u>	Skilled (SNF)	<u>100</u>	<u>36,600</u>	1
2		Skilled Pediatric (SNF/PED)			2
3	<u>97</u>	Intermediate (ICF)	<u>97</u>	<u>35,502</u>	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>197</u>	TOTALS	<u>197</u>	<u>72,102</u>	7

B. Census-For the entire report period.

	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Public Aid Recipient	Private Pay	Other	Total	
8	SNF					8
9	SNF/PED					9
10	ICF	<u>65,045</u>	<u>1,913</u>		<u>66,958</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>65,045</u>	<u>1,913</u>		<u>66,958</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed
bed days on line 7, column 4 92.87%)D. How many bed-hold days during this year were paid by Public Aid?
0 (Do not include bed-hold days in Section B.)E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
NONEF. Does the facility maintain a daily midnight census? YESG. Do pages 3 & 4 include expenses for services or
investments not directly related to patient care?
YES ☐ NO ☒H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES ☐ NO ☒I. On what date did you start providing long term care at this location?
Date started 01/01/78J. Was the facility purchased or leased after January 1, 1978?
YES ☐ Date _____ NO ☒K. Was the facility certified for Medicare during the reporting year?
YES ☐ NO ☒ If YES, enter number
of beds certified _____ and days of care provided _____

Medicare Intermediary _____

IV. ACCOUNTING BASIS

MODIFIED
ACCRUAL ☒ CASH* ☐ CASH* ☐Is your fiscal year identical to your tax year? YES ☒ NO ☐Tax Year: 12/31/00 Fiscal Year: 12/31/00

* All facilities other than governmental must report on the accrual basis.

Print Preview

IF AN ERROR OCCURS IN LINE 8, 16 OR 28, PLEASE ROUND ALL CELLS IN THE APPLICABLE SECTION TO ZERO DECIMAL PLACES.

STATE OF ILLINOIS

Page 3

Facility Name & ID Number **BOURBONNAIS TERRACE** # **0021550** Report Period Beginning: **01/01/2000** Ending: **12/31/2000**
V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	249,528	17,881	9,236	276,645		276,645	0	276,645		1
2	Food Purchase		215,283		215,283		215,283	(823)	214,460		2
3	Housekeeping	179,781	20,138	0	199,919		199,919	0	199,919		3
4	Laundry	97,972	12,892	0	110,864		110,864	0	110,864		4
5	Heat and Other Utilities			125,584	125,584		125,584	124	125,708		5
6	Maintenance	100,962	19,830	21,788	142,580		142,580	3,977	146,557		6
7	Other (specify):*			10,190	10,190		10,190	0	10,190		7
8	TOTAL General Services	628,243	286,024	166,798	1,081,065		1,081,065	3,278	1,084,343		8
	B. Health Care and Programs										
9	Medical Director			4,000	4,000		4,000	0	4,000		9
10	Nursing and Medical Records	1,577,835	37,981	13,989	1,629,805		1,629,805	1,504	1,631,309		10
10a	Therapy	127,454		7,400	134,854		134,854	0	134,854		10a
11	Activities	94,098	4,505	2,400	101,003		101,003	0	101,003		11
12	Social Services	138,526		0	138,526		138,526	0	138,526		12
13	Nurse Aide Training			0				0			13
14	Program Transportation			0				0			14
15	Other (specify):*							0			15
16	TOTAL Health Care and Progra	1,937,913	42,486	27,789	2,008,188		2,008,188	1,504	2,009,692		16
	C. General Administration										
17	Administrative	63,381		544,803	608,184		608,184	(503,728)	104,456		17
18	Directors Fees			0				0			18
19	Professional Services			52,596	52,596		52,596	19,328	71,924		19
20	Dues, Fees, Subscriptions & Promotions			10,973	10,973		10,973	(1,509)	9,464		20
21	Clerical & General Office Expense	150,208	18,417	150,133	318,758		318,758	(88,945)	229,813		21
22	Employee Benefits & Payroll Taxes			395,611	395,611		395,611	(3,360)	392,251		22
23	Inservice Training & Education			6,046	6,046		6,046	98	6,144		23
24	Travel and Seminar			1,830	1,830		1,830	0	1,830		24
25	Other Admin. Staff Transportation			18,067	18,067		18,067	772	18,839		25
26	Insurance-Prop.Liab.Malpractice			71,549	71,549		71,549	1,839	73,388		26
27	Other (specify):*			0				11,360	11,360		27
28	TOTAL General Administration	213,589	18,417	1,251,608	1,483,614		1,483,614	(564,145)	919,469		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,779,745	346,927	1,446,195	4,572,867		4,572,867	(559,363)	4,013,504		29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Print Preview

IF AN ERROR OCCURS IN LINE 37 OR 44, PLEASE ROUND ALL CELLS IN THE APPLICABLE SECTION TO ZERO DECIMAL PLACES.

STATE OF ILLINOIS

Page 4

Facility Name & ID Number **BOURBONNAIS TERRACE**

0021550

Report Period Beginning: 01/01/2000 Ending: 12/31/2000

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY	
		Salary/Wage	Supplies	Other	Total					9	10
	D. Ownership	1	2	3	4	5	6	7	8		
30	Depreciation			46,162	46,162		46,162	12,174	58,336		30
31	Amortization of Pre-Op. & Org.			4,153	4,153		4,153	0	4,153		31
32	Interest			356,210	356,210		356,210	(169,951)	186,259		32
33	Real Estate Taxes			69,132	69,132		69,132	2,349	71,481		33
34	Rent-Facility & Grounds							0			34
35	Rent-Equipment & Vehicles			16,424	16,424		16,424	(8,415)	8,009		35
36	Other (specify):*			14,781	14,781		14,781	0	14,781		36
37	TOTAL Ownership			506,862	506,862		506,862	(163,843)	343,019		37
	Ancillary Expense										
	E. Special Cost Centers										
38	Medically Necessary Transportation							0			38
39	Ancillary Service Centers							0			39
40	Barber and Beauty Shops							0			40
41	Coffee and Gift Shops							0			41
42	Provider Participation Fee			108,154	108,154		108,154	0	108,154		42
43	Other (specify):*							0			43
44	TOTAL Special Cost Centers			108,154	108,154		108,154		108,154		44
45	GRAND TOTAL COST										
	(sum of lines 29, 37 & 44)	2,779,745	346,927	2,061,211	5,187,883	0	5,187,883	(723,206)	4,464,677		45

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

Print Preview

FOR LINES 1 THRU 28, ENTER ONLY ONE LINE REFERENCE PER ROW. IF SIMILAR ADJUSTMENTS ARE MADE TO MORE THAN ONE LINE, ENTER THE ADDITIONAL ADJUSTMENTS ON LINE 29 OF THIS SCHEDULE AND DETAIL THEM ON PAGE 5A.

STATE OF ILLINOIS

Page 5

Facility Name & ID Number **BOURBONNAIS TERRACE**

0021550

Report Period Beginning: **01/01/2000**

Ending: **2/31/2000**

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.

In column 2 below, reference the line on which the particular cost was included. (See instructions.)

		1 Amount	2 Refer- ence	3 OHF USE ONLY	
	NON-ALLOWABLE EXPENSES				
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Program:				3
4	Non-Patient Meals		2		4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space		34		6
7	Sale of Supplies to Non-Patients		10		7
8	Laundry for Non-Patients		4		8
9	Non-Straightline Depreciation	9,893	30		9
10	Interest and Other Investment Income	(172,267)	32		10
11	Discounts, Allowances, Rebates & Refunds		2		11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(823)	2		13
14	Non-Care Related Interest	0	32		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)		25		16
17	Non-Care Related Fees	0	20		17
18	Fines and Penalties		21		18
19	Entertainment	0	20		19
20	Contributions	(243)	20		20
21	Owner or Key-Man Insurance	(3,360)	22		21
22	Special Legal Fees & Legal Retainers		19		22
23	Malpractice Insurance for Individuals		26		23
24	Bad Debt	0	27		24
25	Fund Raising, Advertising and Promotional	(374)	20		25
	Income Taxes and Illinois Personal				
26	Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees		13		27
28	Yellow Page Advertising	(1,249)	20		28
29	Other-Attach Schedule DEFERRED MAINT XIX-H	289	6		29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (168,134)		\$	30

OHF USE ONLY

48		49		50		51		52	
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B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below. (See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(555,072)	SCHED	34
35	Other- Attach Schedule	0	ATTACHED	35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (555,072)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B)	\$ (723,206)		37

*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference
38	Medically Necessary Transport		X	\$	38
39					39
40	Gift and Coffee Shops		X		40
41	Barber and Beauty Shops		X		41
42	Laboratory and Radiology		X		42
43	Prescription Drugs		X		43
44	Exceptional Care Program		X		44
45	Other-Attach Schedule				45
46	Other-Attach Schedule				46
47	TOTAL (C): (sum of lines 38-46)			\$	47

Print Preview

SEE THE PROCEDURES AT THE BOTTOM OF THE WORKSHEET.

IF THESE ARE NOT FOLLOWED, THE FORMULAS WILL NOT FUNCTION PROPERLY.

STATE OF ILLINOIS

Summary A

Facility Name & ID Numb BOURBONNAIS TERRACE

0021550 Report Period Beginning:

01/01/2000

Ending: 12/31/2000

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

Print Summary
A

Operating Expenses		PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
A. General Services														
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(823)	0	0	0	0	0	0	0	0	0	0	(823)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	124	0	0	0	0	0	0	0	124	5
6	Maintenance	289	0	2,521	1,167	0	0	0	0	0	0	0	3,977	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(534)	0	2,521	1,291	0	0	0	0	0	0	0	3,278	8
B. Health Care and Programs														
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	1,504	0	0	0	0	0	0	0	0	1,504	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Program	0	0	1,504	0	0	0	0	0	0	0	0	1,504	16
C. General Administration														
17	Administrative	0	(503,728)	0	0	0	0	0	0	0	0	0	(503,728)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	657	18,555	116	0	0	0	0	0	0	0	19,328	19
20	Fees, Subscriptions & Promotions	(1,866)	0	357	0	0	0	0	0	0	0	0	(1,509)	20
21	Clerical & General Office Expenses	0	9,215	(98,237)	77	0	0	0	0	0	0	0	(88,945)	21
22	Employee Benefits & Payroll Taxes	(3,360)	0	0	0	0	0	0	0	0	0	0	(3,360)	22
23	Inservice Training & Education	0	0	98	0	0	0	0	0	0	0	0	98	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	522	250	0	0	0	0	0	0	0	0	772	25
26	Insurance-Prop.Liab.Malpractice	0	484	1,245	110	0	0	0	0	0	0	0	1,839	26
27	Other (specify):*	0	3,700	7,660	0	0	0	0	0	0	0	0	11,360	27
28	TOTAL General Administration	(5,226)	(489,150)	(70,072)	303	0	0	0	0	0	0	0	(564,145)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(5,760)	(489,150)	(66,047)	1,594	0	0	0	0	0	0	0	(559,363)	29

DO NOT USE DRAG & DROP, CUT OR MOVE COMMANDS. THEY WILL RUIN THE FORMULAS.

1. Enter the information on pages 5 and 5A.
2. For pages 6 thru 6I, the information you enter does not need to be sorted by line reference.
3. For pages 6 thru 6I, a line can be referenced as many times as needed per page.
4. For pages 6 thru 6I, related organization costs for therapy must be referenced as line number 10a.
5. The amounts in the column Q are linked to page 3.

**SEE THE PROCEDURES AT THE BOTTOM OF THE WORKSHEET.
IF THESE ARE NOT FOLLOWED, THE FORMULAS WILL NOT FUNCTION PROPERLY.**

STATE OF ILLINOIS

Summary B

Facility Name & ID Number: **BOURBONNAIS TERRACE**

0021550

Report Period Beginning:

01/01/2000 Ending:

12/31/2000

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

Print Summary
B

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	D. Ownership													
30	Depreciation	9,893	321	738	1,222	0	0	0	0	0	0	0	12,174	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(172,267)	0	0	2,316	0	0	0	0	0	0	0	(169,951)	32
33	Real Estate Taxes	0	0	0	2,349	0	0	0	0	0	0	0	2,349	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	2,352	4,014	(14,781)	0	0	0	0	0	0	0	(8,415)	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(162,374)	2,673	4,752	(8,894)	0	0	0	0	0	0	0	(163,843)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	TOTAL Special Cost Centers	0	0	0	0	0	0	0	0	0	0	0	0	44
	GRAND TOTAL COST													
45	(sum of lines 29, 37 & 44)	(168,134)	(486,477)	(61,295)	(7,300)	0	0	0	0	0	0	0	(723,206)	45

DO NOT USE DRAG & DROP, CUT OR MOVE COMMANDS. THEY WILL RUIN THE FORMULAS.

1. Enter the information on pages 5 and 5A.
2. For pages 6 thru 6I, the information you enter does not need to be sorted by line reference.
3. For pages 6 thru 6I, a line can be referenced as many times as needed per page.
4. For pages 6 thru 6I, related organization costs for therapy must be referenced as line number 10a.
5. The amounts in the column Q are linked to page 4.

SEE THE PROCEDURES AT THE BOTTOM OF THE WORKSHEET. IF THESE ARE NOT FOLLOWED, THE FORMULAS ON THE SUMMARY PAGES WILL NOT FUNCTION PROPERLY.

Facility Name & ID Number: BOWDONNAN TERRACE

STATE OF ILLINOIS

Report Period Beginning: 01/01/2009

Ending: 12/31/2009

Page: 6

Show Pgs 6A thru 6

Show Pgs 6B thru 6

Show Pgs 6A thru 6B

VI. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

OWNERS		RELATED NURSING HOMES		OTHER RELATED BUSINESS ENTITIES	
Name	Ownership %	Name	City	Name	Type of Business
SEE ATTACHED		SEE ATTACHED		SEE MANAGEMENT	ROCKSWOOD
				SEE ENTERPRISE	ROCKSWOOD
				SEE REALTY	ROCKSWOOD
					HOME OPER

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☒ Yes ☐ No

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.							
Schedule	Line	Item	Cost Per Calendar Month	Name of Related Organization	Percent of Related Organization Ownership	Operating Costs of Related Organization	Adjustment for Related Organization Costs (Column 6)
V	17	MANAGEMENT FEES	1,007,805	EMI ENTERPRISE			
V	17	PROPERTY TAXES				20,079	20,079
V	17	REPAIRS/MAINTENANCE				6,015	6,015
V	17	DEANSHIP/CLERICAL				9,215	9,215
V	17	DEANSHIP/CLERICAL				31	31
V	17	DEANSHIP/CLERICAL				31	31
V	17	DEANSHIP/CLERICAL				31	31
V	17	DEANSHIP/CLERICAL				31	31
V	17	DEANSHIP/CLERICAL				31	31
V	17	DEANSHIP/CLERICAL				31	31
V	17	DEANSHIP/CLERICAL				31	31
V	17	DEANSHIP/CLERICAL				31	31
V	17	DEANSHIP/CLERICAL				31	31
V	17	DEANSHIP/CLERICAL				31	31
V	17	DEANSHIP/CLERICAL				31	31
V	17	DEANSHIP/CLERICAL				31	31
V	17	DEANSHIP/CLERICAL				31	31
V	17	DEANSHIP/CLERICAL				31	31
V	17	DEANSHIP/CLERICAL				31	31
V	17	DEANSHIP/CLERICAL				31	31
V	17	DEANSHIP/CLERICAL				31	31
V	17	DEANSHIP/CLERICAL				31	31
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V	17	DEANSHIP/CLERICAL				31	31
V	17	DEANSHIP/CLERICAL				31	31
V	17	DEANSHIP/CLERICAL				31	31
V	17	DEANSHIP/CLERICAL				31	31
V	17	DEANSHIP/CLERICAL					

SEE THE PROCEDURES AT THE BOTTOM OF THE WORKSHEET. IF THESE ARE NOT FOLLOWED, THE FORMULAS ON THE SUMMARY PAGES WILL NOT FUNCTION PROPERLY.

STATE OF ILLINOIS

Page 6A

Facility Name & ID Number BOURBONNAIS TERRACE

0021550

Report Period Beginnin 01/01/2000 Ending: 12/31/2000

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V	21 BOOKKEEPING FEES	\$ 133,156	EKS MANAGEMENT , INC.		\$	\$ (133,156)
16	V	6 PAINTING SALARIES				2,521	2,521
17	V	10 RN CONSULTANT SALARIES				1,504	1,504
18	V	19 PROFESSIONAL FEES				18,555	18,555
19	V	20 WANT ADS				357	357
20	V	21 OFFICE EXPENSE				34,919	34,919
21	V	23 SEMINARS				98	98
22	V	25 TRANSPORTATION				250	250
23	V	26 INSURANCE				1,245	1,245
24	V	27 EMPLOYEE BENEFITS				7,660	7,660
25	V	30 DEPRECIATION				738	738
26	V	35 EQUIPMENT RENT				4,014	4,014
27	V						
28	V						
29	V						
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 133,156			\$ 71,861	\$ * (61,295)

Sum_6A

-133156
2521
1504
18555
357
34919
98
250
1245
7660
738
4014

* Total must agree with the amount recorded on line 34 of Schedule VI.

DO NOT USE DRAG & DROP, CUT OR MOVE COMMANDS. THEY WILL RUIN THE FORMULAS.

1. Enter the information on pages 5 and 5A.
2. For pages 6 thru 6I, the information you enter does not need to be sorted by line reference.
3. For pages 6 thru 6I, a line can be referenced as many times as needed per page.
4. For pages 6 thru 6I, related organization costs for therapy must be referenced as line number 10a.
5. The adjustments entered on this page will automatically transfer to the summary pages.

SEE THE PROCEDURES AT THE BOTTOM OF THE WORKSHEET. IF THESE ARE NOT FOLLOWED, THE FORMULAS ON THE SUMMARY PAGES WILL NOT FUNCTION PROPERLY.

STATE OF ILLINOIS

Facility Name & ID Number BOURBONNAIS TERRACE # 0021550 Report Period Beginnin 01/01/2000 Ending: 12/31/2000

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V	35 OFFICE RENT	\$ 14,781	IME REALTY CORP.		\$	(14,781)
16	V	5 UTILITIES				124	124
17	V	6 REPAIRS & MAINTTENANCE				1,167	1,167
18	V	19 PROFESSIONAL FEES				116	116
19	V	21 OFFICE EXPENSE				77	77
20	V	26 INSURANCE				110	110
21	V	30 DEPRECIATION				1,222	1,222
22	V	32 INTEREST				2,316	2,316
23	V	33 RE TAX				2,349	2,349
24	V						
25	V						
26	V						
27	V						
28	V						
29	V						
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 14,781			\$ 7,481	\$ * (7,300)

Sum_6B

-14781
124
1167
116
77
110
1222
2316
2349

* Total must agree with the amount recorded on line 34 of Schedule VI.

DO NOT USE DRAG & DROP, CUT OR MOVE COMMANDS. THEY WILL RUIN THE FORMULAS.

1. Enter the information on pages 5 and 5A.
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3. For pages 6 thru 6I, a line can be referenced as many times as needed per page.
4. For pages 6 thru 6I, related organization costs for therapy must be referenced as line number 10a.
5. The adjustments entered on this page will automatically transfer to the summary pages.

SEE THE PROCEDURES AT THE BOTTOM OF THE WORKSHEET. IF THESE ARE NOT FOLLOWED, THE FORMULAS ON THE SUMMARY PAGES WILL NOT FUNCTION PROPERLY.

STATE OF ILLINOIS

Page 6C

Facility Name & ID Number BOURBONNAIS TERRACE

0021550

Report Period Beginn 01/01/2000 Ending: 12/31/2000

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V		\$			\$	\$
16	V						
17	V						
18	V						
19	V						
20	V						
21	V						
22	V						
23	V						
24	V						
25	V						
26	V						
27	V						
28	V						
29	V						
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$			\$	\$ *

Sum_6C

* Total must agree with the amount recorded on line 34 of Schedule VI.

DO NOT USE DRAG & DROP, CUT OR MOVE COMMANDS. THEY WILL RUIN THE FORMULAS.

1. Enter the information on pages 5 and 5A.
2. For pages 6 thru 6I, the information you enter does not need to be sorted by line reference.
3. For pages 6 thru 6I, a line can be referenced as many times as needed per page.
4. For pages 6 thru 6I, related organization costs for therapy must be referenced as line number 10a.
5. The adjustments entered on this page will automatically transfer to the summary pages.

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V		\$			\$	\$
16	V						
17	V						
18	V						
19	V						
20	V						
21	V						
22	V						
23	V						
24	V						
25	V						
26	V						
27	V						
28	V						
29	V						
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$			\$	\$ *

Sum_6D

* Total must agree with the amount recorded on line 34 of Schedule VI.

DO NOT USE DRAG & DROP, CUT OR MOVE COMMANDS. THEY WILL RUIN THE FORMULAS.

1. Enter the information on pages 5 and 5A.
2. For pages 6 thru 6I, the information you enter does not need to be sorted by line reference.
3. For pages 6 thru 6I, a line can be referenced as many times as needed per page.
4. For pages 6 thru 6I, related organization costs for therapy must be referenced as line number 10a.
5. The adjustments entered on this page will automatically transfer to the summary pages.

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	MORRIS ESFORMES	GENERAL PART	ADMISTRATIVE		ATTACHED SCHEDULE			SALARY	\$ 20,075	17-8	1
2	BERNARD COHEN	GENERAL PART	ADMINISRATIVE					CONSULTING	21,000	17-3	2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 41,075		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REI

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees)
**FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME
 ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION**

Print Preview

| the name(s)
PORTS.

Facility Name & ID Number **BOURBONNAIS TERRACE**# **0021550** Report Period Beginning: **01/01/2000**Ending: **1/31/2000**

VIII. ALLOCATION OF INDIRECT COSTS

Show Pgs 8A thru 8D

Show Pgs 8E thru 8I

Hide Pgs 8A thru 8I

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☒ NO ☐

Name of Related Organization **EMI ENTERPRISES**Street Address **3737 W. ARTHUR AVE.**City / State / Zip Code **LINCOLNWOOD**Phone Number **(847)674-5795**Fax Number **(847)674-5795**

B. Show the allocation of costs below. If necessary, please attach worksheets.

1	2	3	4	5	6	7	8	9		
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6		
1	17	OFFICER SALARY	PATIENT DAYS	617,052	11	\$ 185,000	\$ 185,000	66,958	\$ 20,075	1
2	19	ACCOUNTING FEES	PATIENT DAYS	617,052	11	6,053	66,958	657		2
3	21	OFFICE EXPENSE	PATIENT DAYS	617,052	11	84,917	64,123	66,958	9,215	3
4	25	TRANSPORTATION	PATIENT DAYS	617,052	11	4,810	66,958	522		4
5	26	INSURANCE	PATIENT DAYS	617,052	11	4,462	66,958	484		5
6	27	EMPLOYEE BENEFITS	PATIENT DAYS	617,052	11	34,099	66,958	3,700		6
7	30	DEPRECIATION	PATIENT DAYS	617,052	11	2,964	66,958	322		7
8	35	AUTO LEASE	PATIENT DAYS	617,052	11	21,677	66,958	2,352		8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 343,982	\$ 249,123		\$ 37,327	25

Print Preview

Facility Name & ID Number **BOURBONNAIS TERRACE**# **0021550** Report Period Beginning: **01/01/2000**Ending: **12/31/2000**

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☒ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization **EKS MGMT**Street Address **3737 W. ARTHUR**City / State / Zip Code **LINCOLNWOOD , IL. 60712**Phone Number **(847)674-1946**Fax Number **(847)674-1962**

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	6	PAINTING SALARIES	PATIENT DAYS	617,052	11	\$ 23,229	\$ 23,229	66,958	\$ 2,521	1
2	10	RN CONSULTANT SALARY	PATIENT DAYS	617,052	11	13,856	13,856	66,958	1,504	2
3	19	PROFESSIONAL FEES	PATIENT DAYS	617,052	11	170,994	131,431	66,958	18,555	3
4	20	WANT ADS	PATIENT DAYS	617,052	11	3,290		66,958	357	4
5	21	OFFICE EXPENSE	PATIENT DAYS	617,052	11	321,801	269,147	66,958	34,920	5
6	23	SEMINARS	PATIENT DAYS	617,052	11	905		66,958	98	6
7	25	TRANSPORTATION	PATIENT DAYS	617,052	11	2,302		66,958	250	7
8	26	INSURANCE	PATIENT DAYS	617,052	11	11,476		66,958	1,245	8
9	27	EMPLOYEE BENEFITS	PATIENT DAYS	617,052	11	70,589		66,958	7,660	9
10	30	DEPRECIATION	PATIENT DAYS	617,052	11	6,797		66,958	738	10
11	35	EQUIPMENT RENT	PATIENT DAYS	617,052	11	36,988		66,958	4,014	11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 662,227	\$ 437,663		\$ 71,862	25

Facility Name & ID Number **BOURBONNAIS TERRACE**# **0021550** Report Period Beginning: **01/01/2000**Ending: **12/31/2000**

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☒ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization **IME**Street Address **3737 W. ARTHUR**City / State / Zip Code **LINCOLNWOOD, IL. 60712**Phone Number **(847)674-1946**Fax Number **(847)674-1962**

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e., Days, Direct Cost Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	5	UTILITIES	INCOME	100	11	\$ 1,685	\$	7	\$ 124	1
2	6	REPAIRS & MAINTTENAN	INCOME	100	11	15,902		7	1,167	2
3	19	PROFESSIONAL FEES	INCOME	100	11	1,575		7	116	3
4	21	OFFICE EXPENSE	INCOME	100	11	1,047		7	77	4
5	26	INSURANCE	INCOME	100	11	1,504		7	110	5
6	30	DEPRECIATION	INCOME	100	11	16,647		7	1,222	6
7	32	INTEREST	INCOME	100	11	31,549		7	2,316	7
8	33	RE TAX	INCOME	100	11	32,000		7	2,349	8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 101,909	\$		\$ 7,481	25

Facility Name & ID Number **BOURBONNAIS TERRACE**# **0021550** Report Period Beginning: **01/01/2000**Ending: **12/31/2000**

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

B. Show the allocation of costs below. If necessary, please attach worksheets.

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

Facility Name & ID Number BOURBONNAIS TERRACE# 0021550 Report Period Beginning: 01/01/2000Ending: 12/31/2000

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

B. Show the allocation of costs below. If necessary, please attach worksheets.

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6		7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense		
		YES	NO				Original	Balance					
	A. Directly Facility Related												
	Long-Term												
1	LASALLE NATIONAL BANK		X	MORTGAE	VARIES	08/01/95	\$ 4,910,000	\$ 4,103,446	07/31/15		\$ 339,752	1	
2												2	
3												3	
4												4	
5												5	
	Working Capital												
6	LASALLE NATIONAL BANK		X	LINE OF CREDIT	INTEREST	REVOLV	220,000	158,468	REVOLV	PRIME +	16,458	6	
7	IME REALTY ALLOCATION											7	
8												8	
9	TOTAL Facility Related						\$ 5,130,000	\$ 4,261,914			\$ 356,210	9	
	B. Non-Facility Related*												
10												10	
11												11	
12												12	
13												13	
14	TOTAL Non-Facility Related						\$	\$			\$	14	
15	TOTALS (line 9+line14)						\$ 5,130,000	\$ 4,261,914			\$ 356,210	15	

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7.

(See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2.

(See instructions.)

Print Preview

Facility Name & ID Number **BOURBONNAIS TERRACE**# **0021550** Report Period Beginning: **01/01/2000** Ending: **12/31/2000****IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)****B. Real Estate Taxes**

1. Real Estate Tax accrual used on 1999 report.	\$	68,650	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	\$	68,891	2
3. Under or (over) accrual (line 2 minus line 1).	\$	241	3
4. Real Estate Tax accrual used for 2000 report. (Detail and explain your calculation of this accrual on the lines below.)	\$	68,891	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)	\$		5
6. Subtract a refund of real estate taxes used previously to calculate a payment rate. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ For 19 Tax Year. (Attach a copy of the real estate tax appeal board's decision.)	\$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6	\$	69,132	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	1995	1996	1997	1998	1999
	69,846	72,597	70,821	68,649	68,891
	8	9	10	11	12

THE CURRENT YEAR REAL ESTATE TAX ACCRUAL IS BASED ON ~ 100% OF THE PRIOR YEAR REAL ESTATE TAX BILL

THE PAYMENT ON LINE 2 APPLIES TO THE 1999 TAX YEAR.

FOR OFF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 1999 \$	13
14	PLUS APPEAL COST FROM LINE 5 \$	14
15	LESS REFUND FROM LINE 6 \$	15
16	AMOUNT TO USE FOR RATE CALCULATIC \$	16

NOTES:

1. Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.
This denial must be no more than four years old at the time the cost report is filed.

Print Preview

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 43,232 B. General Construction Type: Exterior BRICK Frame _____ Number of Stories _____C. Does the Operating Entity? ☒ (a) Own the Facility ☐ (b) Rent from a Related Organization. ☐ (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? ☒ (a) Own the Equipment ☐ (b) Rent equipment from a Related Organization. ☐ (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? ☐ YES ☒ NO
If so, please complete the following:1. Total Amount Incurred: 0 2. Number of Years Over Which it is Being Amortized: _____3. Current Period Amortization: 0 4. Dates Incurred: _____

Nature of Costs: _____

(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	NURSING HOME	165,000		\$ 184,000	1
2				3,600	2
3	TOTALS	165,000		\$ 187,600	3

Print Preview

IF AN ERROR OCCURS IN LINE 35, COLUMN 4, PLEASE
REMOVE THE TEXT FROM COLUMN 2 OR 3.

Show Pgs 12A & 12B

Show Pgs 12C and 12D

Hide Pgs 12A thru 12D

STATE OF ILLINOIS

Page 12

Facility Name & ID Number BOURBONNAIS TERRACE

0021550

Report Period Beginning:

01/01/200(Ending: 12/31/2000

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	197		1975	1974	\$ 1,838,000	\$ 0	25	\$	\$	\$	4
5											5
6											6
7				IME ALLOCATION		0		0			7
8											8
PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3											
9	LEASEHOLD IMPROVEMENT			1981	54,211	0	10	0		54,211	9
10	LEASEHOLD IMPROVEMENT			1982	17,608	0	10	0		17,608	10
11	ROOFING			1983	1,875	0	15	0		1,875	11
12	ROOFING			1984	6,215	249	18	249		5,260	12
13	IMPROVEMENTS			1987	21,900	695	31.5	695		9,730	13
14	STONE DRIVE			1990	7,800	248	31.5	248		2,573	14
15	IMPROVEMENTS			1991	26,075	828	31.5	828		7,624	15
16	IMPROVEMENTS			1992	38,485	1,222	31.5	1,222		10,387	16
17	ROOFING			1993	21,500	551	39	551		5,467	17
18	GUTTERS			1994	7,248	186	39	186		1,232	18
19	CONCRETE			1994	7,967	204	39	204		1,301	19
20	FLOOR			1995	766	20	39	20		119	20
21	TILE			1995	1,580	40	39	40		240	21
22	FLOOR			1995	934	24	39	24		141	22
23	CONCRETE			1995	2,500	64	39	64		328	23
24	TILES			1996	5,820	149	39	149		689	24
25	SEWERS			1996	10,000	256	39	256		1,163	25
26	TILES			1996	16,056	412	39	412		1,871	26
27	ROOF			1996	21,650	555	39	555		2,475	27
28	CONCRETE			1996	7,949	204	39	204		893	28
29	SCREENS			1996	1,424	37	39	37		159	29
30	DISPOSER BASE UNIT			1996	732	19	39	19		77	30
31	FLOORING IMPROVEMENTS			1997	16,979	435	39	435		1,541	31
32	WINDOWS			1998	1,680	43	39	43		129	32
33	INSTALL NEW SIGN			1998	2,643	68	39	68		139	33
34	NURSES STATION			1999	3,520	90	39	90		162	34
35	KITCHEN A/C UNIT			1999	6,696	172	39	172		251	35
36	PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3				\$ #VALUE!	\$ 6,771		\$ 6,771	\$	\$ 127,645	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Print Preview

IF AN ERROR OCCURS IN LINE 35, COLUMN 4, PLEASE
REMOVE THE TEXT FROM COLUMN 2 OR 3.

Print Page 12A

STATE OF ILLINOIS

Page 12A

Facility Name & ID Numbe BOURBONNAIS TERRACE

0021550

Report Period Beginning:

01/01/200(Ending: 12/31/2000

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					\$	\$		\$	\$	\$	4
5											5
6											6
7											7
8											8
	PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3										
9		FURNISHINGS - CARPET/WALLPAPER		1999	16,384	4,012	7	4,012		6,353	9
10		FENCE		2000	2,800	148	15	148		148	10
11		DUCT WORK		2000	14,000	64	27.5	64		64	11
12		IN WALL HEATERS		2000	12,407	432	27.5	432		432	12
13		IN WALL HEATERS		2000	4,378	33	27.5	33		33	13
14		FURNISHINGS		2000	23,248	3,322	7	3,322		3,322	14
15		DOORS		2000	881	31	27.5	31		31	15
16											16
17											17
18											18
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31											31
32											32
33											33
34											34
35											35
36		PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3			\$ #VALUE!	\$ 8,042		\$ 8,042	\$	\$ 10,383	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Print Preview

IF AN ERROR OCCURS IN LINE 35, COLUMN 4, PLEASE
REMOVE THE TEXT FROM COLUMN 2 OR 3.

Print Page 12B

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Facility Name & ID Numbe BOURBONNAIS TERRACE

0021550

Report Period Beginning: 01/01/2000 Ending: 12/31/2000

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					\$	\$		\$	\$	\$	4
5											5
6											6
7											7
8											8
	PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3										
9											9
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29											29
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31											31
32											32
33											33
34											34
35											35
36	PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3				\$ #VALUE!	\$		\$	\$	\$	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Print Preview

IF AN ERROR OCCURS IN LINE 35, COLUMN 4, PLEASE
REMOVE THE TEXT FROM COLUMN 2 OR 3.

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STATE OF ILLINOIS

0021550

Report Period Beginning:

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01/01/2000 Ending: 12/31/2000

Facility Name & ID Numbe BOURBONNAIS TERRACE

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					\$	\$		\$	\$	\$	4
5											5
6											6
7											7
8											8
	PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3										
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14											14
15											15
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29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3				\$ #VALUE!	\$		\$	\$	\$	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Print Preview

IF AN ERROR OCCURS IN LINE 35, COLUMN 4, PLEASE
REMOVE THE TEXT FROM COLUMN 2 OR 3.

Print Page 12D

STATE OF ILLINOIS

Page 12D

Facility Name & ID Numbe BOURBONNAIS TERRACE

0021550

Report Period Beginning: 01/01/2000 Ending: 12/31/2000

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					\$	\$		\$	\$	\$	4
5											5
6											6
7											7
8											8
	PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3										
9											9
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31											31
32											32
33											33
34											34
35											35
36	PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3				\$ #VALUE!	\$		\$	\$	\$	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Print Preview

Facility Name & ID Number **BOURBONNAIS TERRACE**# **0021550**Report Period Beginning: **01/01/2000** Ending: **12/31/2000****XI. OWNERSHIP COSTS (continued)****C. Equipment Depreciation-Excluding Transportation. (See instructions.)**

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Componen Life 5	Accumulated Depreciation 6	
37	Purchased in Prior Years	\$ 380,916	\$ 27,835	\$ 40,043	\$ 12,208	7-10 YR	\$ 224,915	37
38	Current Year Purchases	23,972	3,514	1,199	(2,315)	5-10 YR	1,199	38
39	Fully Depreciated Assets	259,305					259,305	39
40	RELATED PARTY		2,281	2,281				40
41	TOTALS	\$ 664,193	\$ 33,630	\$ 43,523	\$ 9,893		\$ 485,419	41

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
42				\$	\$	\$	\$		\$	42
43										43
44										44
45										45
46	TOTALS			\$	\$	\$	\$		\$	46

E. Summary of Care-Related Assets

	1	2	
	Reference	Amount	
47	Total Historical Cost (line 3,col.4 + line 36,col.4 + line 41,col.1 + line 46,col.4)	\$ #VALUE!	47
48	Current Book Depreciation (line 36,col.5 + line 41,col.2 + line 46,col.5)	\$ 48,443	48
49	Straight Line Depreciation (line 36,col.7 + line 41,col.3 + line 46,col.6)	\$ 58,336	49
50	Adjustments (line 36,col.8 + line 41,col.4 + line 46,col.7)	\$ 9,893	50
51	Accumulated Depreciation (line 36,col.9 + line 41,col.6 + line 46,col.9)	\$ 623,447	51

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
52		\$	\$	\$	52
53					53
54					54
55					55
56					56
57	TOTALS	\$	\$	\$	57

G. Construction-in-Progress

	Description	Cost	
58		\$	58
59			59
60			60
61		\$	61

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Print Preview

XII. RENTAL COSTS**A. Building and Fixed Equipment (See instructions.)**

1. Name of Party Holding Lease: _____

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4? _____

If NO, see instructions.

☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5								5
6								6
7	TOTAL				\$			7

8. List separately any amortization of lease expense included on page 4, line 34. _____

This amount was calculated by dividing the total amount to be amortized _____
by the length of the lease _____.9. Option to Buy: ☐ YES ☐ NO Terms: _____ ***B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)**15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO16. Rental Amount for movable equipm: \$ _____ Description: **SEE SCHEDULE ATTACHED**

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			\$	\$	17
18					18
19					19
20					20
21	TOTAL		\$	\$	21

10. Effective dates of current rental agreement:

Beginning _____

Ending _____

11. Rent to be paid in future years under the current rental agreement:

Fiscal Year Ending Annual Rent

12. 2001 \$ _____13. 2002 \$ _____14. 2003 \$ _____

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Print Preview

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Facility Name & ID Number BOURBONNAIS TERRACE # 0021550 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

<p>1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?</p> <p style="text-align: right;"> <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO </p> <p>If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	<p>2. CLASSROOM PORTION:</p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER AIDE _____</p>	<p>3. CLINICAL PORTION:</p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER AIDE _____</p>
<p>THE FACILITY HIRES ONLY TRAINED AIDES.</p>		

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	\$	\$	\$	\$
10	SUM OF line 9, col. 1 and 2 (e)	\$			

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
 (b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
 (c) For in-house training programs only. Do not include fringe benefits.
 (d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities

\$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

- (e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
 (f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

Print Preview

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Facility Name & ID Number **BOURBONNAIS TERRACE**# **0021550** Report Period Beginning: **01/01/2000** Ending: **12/31/2000****XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)**

		1	2	3	4	5	6	7	8		
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)		
			Units of Service	Cost	Units	Cost					
					1	Licensed Occupational Therapist		hrs	\$		
2	Licensed Speech and Language Development Therapist			hrs							2
3	Licensed Recreational Therapist			hrs							3
4	Licensed Physical Therapist			hrs							4
5	Physician Care			visits							5
6	Dental Care			visits							6
7	Work Related Program			hrs							7
8	Habilitation			hrs							8
9	Pharmacy			# of prescripts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)			hrs							10
11	Academic Education			hrs							11
12	Exceptional Care Program										12
13	Other (specify):										13
14	TOTAL			\$		\$	\$		\$		14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

[Print Preview](#)

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Facility Name & ID Number BOURBONNAIS TERRACE

0021550

Report Period Beginning: 01/01/2000

Ending:

12/31/2000

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2000 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 327,877	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	687,352		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	122,099		6
7	Other Prepaid Expenses	16,128		7
8	Accounts Receivable (owners or related parties)	2,112,360		8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 3,265,816	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	187,600		13
14	Buildings, at Historical Cost	1,838,000		14
15	Leasehold Improvements, at Historical Cost	346,279		15
16	Equipment, at Historical Cost	703,825		16
17	Accumulated Depreciation (book methods)	(2,565,436)		17
18	Deferred Charges	83,056		18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): Amort of Def Loan Costs	(27,184)		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 566,140	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 3,831,956	\$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 160,237	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	158,468		29
30	Accrued Salaries Payable	91,568		30
31	Accrued Taxes Payable (excluding real estate taxes)	37,528		31
32	Accrued Real Estate Taxes(Sch.IX-B)	68,891		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes	10,607		35
	Other Current Liabilities(specify):			
36	Due to Related Parties	16,054		36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 543,353	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable	4,103,446		40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 4,103,446	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 4,646,799	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ (814,843)	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 3,831,956	\$	48

*(See instructions.)

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XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (944,170)	1
2	Restatements (describe):		2
3	1999 State Replacement Tax	(9,324)	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (953,494)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	693,920	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	(555,269)	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 138,651	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ (814,843)	24 *

* This must agree with page 17, line 47.

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STATE OF ILLINOIS

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Facility Name & ID Number BOURBONNAIS TERRACE

0021550

Report Period Beginning: 01/01/2000

Ending:

12/31/2000

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

Revenue		1	Amount	
A. Inpatient Care				
1	Gross Revenue -- All Levels of Care	\$	5,720,143	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$	5,720,143	3
B. Ancillary Revenue				
4	Day Care			4
5	Other Care for Outpatients			5
6	Therapy			6
7	Oxygen			7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$		8
C. Other Operating Revenue				
9	Payments for Education			9
10	Other Government Grants			10
11	Nurses Aide Training Reimbursements			11
12	Gift and Coffee Shop			12
13	Barber and Beauty Care			13
14	Non-Patient Meals			14
15	Telephone, Television and Radio			15
16	Rental of Facility Space			16
17	Sale of Drugs			17
18	Sale of Supplies to Non-Patients			18
19	Laboratory			19
20	Radiology and X-Ray			20
21	Other Medical Services			21
22	Laundry			22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$		23
D. Non-Operating Revenue				
24	Contributions			24
25	Interest and Other Investment Income***		172,267	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$	172,267	26
E. Other Revenue (specify):****				
27	Settlement Income (Insurance, Legal, Etc.)			27
28	DISCOUNTS			28
28a				28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$		29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$	5,892,410	30

Expenses		2	Amount	
A. Operating Expenses				
31	General Services	\$	1,081,065	31
32	Health Care		2,008,188	32
33	General Administration		1,483,614	33
B. Capital Expense				
34	Ownership		506,862	34
C. Ancillary Expense				
35	Special Cost Centers			35
36	Provider Participation Fee		108,154	36
D. Other Expenses (specify):				
37				37
38				38
39				39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$	5,187,883	40
41	Income before Income Taxes (line 30 minus line 40)**		704,527	41
42	Income Taxes		10,607	42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$	693,920	43

* This must agree with page 4, line 45, column 4.

** Does this agree with taxable income (loss) per Federal Income Tax Return? YES If not, please attach a reconciliation.

*** See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.

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XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	2,080	2,295	\$ 56,840	\$ 24.77	1
2	Assistant Director of Nursing					2
3	Registered Nurses	10,787	13,101	213,551	16.30	3
4	Licensed Practical Nurses	18,786	21,176	318,004	15.02	4
5	Nurse Aides & Orderlies	75,186	87,444	953,096	10.90	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	7,573	8,557	127,454	14.89	8
9	Activity Director					9
10	Activity Assistants	9,086	10,753	94,098	8.75	10
11	Social Service Workers	12,869	13,725	138,526	10.09	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	20,492	23,739	249,528	10.51	15
16	Dishwashers					16
17	Maintenance Workers	4,970	5,187	100,962	19.46	17
18	Housekeepers	18,384	20,541	179,781	8.75	18
19	Laundry	7,609	8,715	97,972	11.24	19
20	Administrator	2,080	2,234	63,381	28.37	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	14,263	18,125	150,208	8.29	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify) Quality Assuran	1,993	2,077	36,344	17.50	33
34	TOTAL (lines 1 - 33)	206,158	237,669	\$ 2,779,745 *	\$ 11.70	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	M	\$ 9,200	1-3	35
36	Medical Director	O	4,000	9-3	36
37	Medical Records Consultant	N	2,465	10-3	37
38	Nurse Consultant	T	0	10-3	38
39	Pharmacist Consultant	H	6,299	10-3	39
40	Physical Therapy Consultant	L	2,825	10a-3	40
41	Occupational Therapy Consulta	Y	4,575	10a-3	41
42	Respiratory Therapy Consultan	F	0	10a-3	42
43	Speech Therapy Consultant	E	0	10a-3	43
44	Activity Consultant	E	2,400	11-3	44
45	Social Service Consultant	S	0	12-3	45
46	Other(specify)				46
47	PSYCHO-SOCIAL CONSULTANT		2,200	10-3	47
48					48
49	TOTAL (lines 35 - 48)		\$ 33,964		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses		\$	10-3	50
51	Licensed Practical Nurses			10-3	51
52	Nurse Aides			10-3	52
53	TOTAL (lines 50 - 52)		\$		53

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Facility Name & ID Num BOURBONNAIS TERRACE

0021550

Report Period Beginning:

01/01/2000

Ending:

12/31/2000

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).

(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1997	FY1998	FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005
1	PAINT/DECORATI	1997	\$ 6,090	3 YR	\$ 1,015	\$ 2,030	\$ 2,030	\$ 1,015	\$	\$	\$	\$	\$
2	PAINT/DECORATI	1998	2,585	3 YR		431	862	862	430				
3	PAINT/DECORATI	1999	2,551	3 YR			425	850	850	426			
4	PAINT/DECORATI	2000	2,926	3 YR				488	975	975	488		
5													
6													
7													
8													
9													
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16													
17													
18													
19													
20	TOTALS		\$ 14,152		\$ 1,015	\$ 2,461	\$ 3,317	\$ 3,215	\$ 2,255	\$ 1,401	\$ 488	\$	\$

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